DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Division of Integrated Health Systems/Family and Children's Health Programs Group/Center for Medicaid and State Operations

August 29, 2003

Mr. Roger Gantz
State of Washington
Department of Social and Health Services
PO Box 45010
Olympia, WA 98504-5010

Dear Mr. Gantz:

This letter serves as a follow-up to the telephone conversation of August 15th between you and CMS staff regarding the Washington section 1115 premium proposal dated July 21, 2003. As discussed in the phone conference, we have identified and outlined the following major issues below. Additionally, we have included specific questions from our internal 1115 review team to which we would like your response as we continue our review.

September 1, 2003 Timeframe for Approval

You have requested approval by September 1, 2003 in accordance with the Washington State 2003-2005 Biennial Budget Act. We indicated that we could not approve this request by that date because of the nature of our review process. We agreed that October 1, 2003 would be a more realistic target; however, CMS cannot commit to approval by that date.

AI/AN premium exemption

You have requested to exempt American Indian/Alaska Native Children from premiums--this is also an issue under the Office of Civil Rights (OCR) consideration for Oregon as well. We hope to receive an opinion from OCR within the coming weeks.

Budget Neutrality

On the phone conference, we requested that you specify which trend rate you are requesting, and submit the data in federal fiscal years across five years of the demonstration, including the base year. You clarified that your premium request did not involve Title XXI funds, but you would adjust SCHIP through a State Plan Amendment. You indicated that budget neutrality numbers would be revised.

Evaluation Plan

We have asked you to provide details on how the State will evaluate the demonstration with grant funding and we agreed to provide additional guidance. In the event that a child who loses eligibility gets sick, how will you assess impact on the demonstration? By direct means (e.g., survey or other data collection method) or indirectly through analysis of impact on hospitals and other delivery systems, uncompensated care, or emergency room use? What analysis will be done if grant funding is unavailable?

Should you require further assistance, please do not hesitate to contact Juli Harkins, Project Officer, at (410) 786-1028.

Sincerely,

/s/
Mike Fiore
Director
Division of Integrated Health Systems

REQUEST FOR ADDITIONAL INFORMATION
WASHINGTON SECTION 1115 DEMONSTRATION PROPOSAL

Budget Neutrality/Funding Questions

1) Please provide an explanation of the abbreviations/acronyms used on the budget neutrality spreadsheets.

2) Is it realistic to predict savings since the children to remain in the program are likely to be more costly/sicker children, thus increasing the per capita costs for the group?

3) What other impacts does the State expect in expenditures due to the disenrollment of 22,000+ children (e.g. increased ER costs) that might offset savings?

4) In analyzing the income level, amount of premium charged, and the percentage of income represented by the premium amount for a family of three with one child, it appears that lower income families are paying a higher percentage of their income in premiums than higher income families. What is the rationale for this?

5) Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking states to confirm to CMS that providers retain 100 percent of the payments. Do providers retain all of the Medicaid payments (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, other) including the Federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.) For DSH payments, please also indicate if the State is making DSH payments in excess of 100% of costs and the percentage of payments in excess of 100% that are returned to the State, local governmental entity, or any other intermediary organization.

6) Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditures and State share amounts for each type of Medicaid payment. If any of the state share is being provided through the use local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).

7) Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

8) Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

9) Does any public provider receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) that in the aggregate exceed its reasonable costs of providing services? If payments exceed the cost of services, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Premium Arrears/Eligibility Termination

1) How frequently and through what means will heads of household be billed? How will the State track when families have reached their 3% of income threshold?

2) How will parents be notified that they are past due and about to be disenrolled?

3) Will there be any type of fair hearing process when eligibility is terminated?

Page Three—Request for Additional Information

4) What provisions does the State have in place to address issues that might arise for children who are mid-treatment (e.g., chemotherapy) when eligibility is terminated due to non-payment of premiums, or whose premiums are not paid due to parental incapacitation (e.g., hospitalization)?

5) If past due premiums are written off by the State, does that mean individuals then become eligible without repayment?

6) How will sponsorship be handled if bills are sent to heads of household? How will problems be handled if disputes or errors occur between the State and sponsors? Who are the sponsors? How will they be recruited/identified? How will they be logistically and programmatically linked into the program?

7) Which children does the State expect to lose coverage/be disenrolled due to lack of premium payment? The least costly/most unhealthy?

8) Please note that while children ages 6-18 with incomes above 100% FPL are considered a Categorically Needy optional group in the State Plan, they are part of a mandatory group under section 1902(a)(10)(A)(i) of the Social Security Act (SSA).

Evaluation Plan

1) On page 24, XIV.B, only one item in Table 3 relates to risk profiles. What of monitoring health status as described in the document?

2) The quality of encounter data generated by MCOs has historically been an issue. What impact will that have on the program implementation, monitoring, and evaluation? How does the State plan to monitor for and mitigate any problems that might occur?

3) What steps have been taken to ensure the State can merge data from the FFS, Managed Care, and mental health data systems for the purpose of monitoring and evaluation?

Other

1) On page 17, XI.A, Will the CN optional children under age 1 include fetuses?

2) On page 18, XI.A, the CN optional children age 6 through 18 is not consistent with the chart illustrating Income Standards (ages 6-19). Please clarify.

Page Four—Request for Additional Information

3) On page 23, Section XIII, what is the potential impact of this proposed program change on services delivered through other systems (e.g., mental health) whose funding is likely to decrease because it is based on number of eligibles? How does the State intend to monitor and mitigate any negative impact?

4) What is the potential impact on the managed care MCOs and systems because of adverse selection and the related increase in risk? How does the State intend to monitor for and mitigate any negative impact?

5) Regarding page 24, section XIV.A, what is the rationale for thinking that the outcome for numbers of eligibles lost will differ so significantly from the outcomes described in previous studies (49% if premiums equal 3% of income)?

6) Regarding page, 28, section XVI.B, are affected MAA staff, especially those responsible for the customer serve provision, not to be trained? This indicates that they will only have access to the website.